Rheumatoid Arthritis

The goal of rheumatoid arthritis (RA) is to prevent or control joint damage, prevent loss of function, and decrease pain.[1]

EARLY Treatment
Disease is non aggressive = x-ray is negative for erosion, anti-CCP negative; or CRP/ESR normal.

Documented Diagnosis of Rheumatoid Arthritis: No Step Therapy requirement for COX 2 agents. TAR NOT REQUIRED

Patient Education[1]**:**
1. PT and OT evaluation.
2. Arthritis Self Management Course, People with Arthritis Can Exercise, Arthritis Foundation Aquatics[5]
3. Adaptation of Self Management Course in other languages, significant improvement in self-efficacy and symptoms noted[10]

The High Risk Patient[7]*:*
1. **Age ≥ 65 & on diuretic**
2. **Age ≥ 65 & on ACE**
3. **CHF**
4. **Cirrhosis**
5. **Pre-existing Renal Disease**
6. **ASHD**[7]

If high dose NSAID is added...
DUR alert sent to pharmacies to communicate back to physicians
Call MD and begin at modest dose, have patient report s/s fluid retention[7]

Consider prior authorization for high-risk patients, with pre-existing renal disease or cirrhosis[7].

Labs: RF & ESR or CRP[1]
Anti-CCP, X-Ray of hand and feet

The adjunctive treatment of early RA symptoms w/ quick acting analgesics[1] consider:
- *APAP*, or *ASA* & or topical application of capsaicin cream
- *RA flares: temporary use of tramadol, opioids, or corticosteroids*

For chronic pain control:
- **NSAIDs:** *Diclofenac sodium, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, meloxicam, nabumetone, naproxen, piroxicam, sulindac, and tolmetin,* diflunisal, oxaprozin, ketorolac, mefenamic acid, etodolac.
- **Non-Acetylated NSAIDs:** *Salsalate or choline salicylate & magnesium salicylate*
- **Use Cyclooxygenase (COX)-2 Inhibitor:**
  - If tried and failed 2 of the above agents with claims history of 30 days of continuous use in the past 120 days. *OR*
  - Known risk factor (required one criteria to be met): Diagnosis of RA, age ≥ 65 years, history of ulcer, inferred Dx - Rx PPI or H2 antagonist, concurrent use of corticosteroid, concurrent use of anticoagulants, inferred Dx - *misoprostol* and an NSAID.

WHEN RA IS DIAGNOSED *ADD and Begin*

Disease Modifying Anti-Rheumatic Drugs (DMARDs - *should begin within 3 months of a diagnosis of RA*[1]**).** Failure of single DMARD refer patient to a rheumatologist[1]
- Consider h*ydroxychloroquine* (HCQ), s*ulfasalazine* (SSZ), m*ethotrexate* (MTX) for safety, convenience, and cost.[1] Leflunomide *(Arava) is considered a first line agent*
- *Azathioprine* (AZA), cyclosporine, minocycline, D-penicillamine, g*old salts*, *(secondary agents).*
- *Cyclophosphamide (for vasculitis or other serious extra-articular form of RA).*

Rule out hepatic disease prior to initiating therapy with MTX or Leflunomide.

Adjunctive therapy with quick acting analgesics + DMARDs

None of the NSAIDs (including COX-2) are renal sparing.
- Use NSAIDs cautiously in recipients with significant risk of HTN or renal impairment.[3]
- Use of NSAIDs and COX–2 inhibitors should be avoided in conditions associate with diminished intravascular volume or edema, such as CHF, nephrotic syndrome, or cirrhosis and in patients with serum creatinine > 2.5mg/dl.[7] Chronic kidney failure defined as GFR <60ml/min/1.73m^2 or at least 3 months of either structural or functional abnormalities of the kidney[8]
- The use of a COX-2 agent has been reported to be associated with a higher rate of thrombotic events (including more myocardial infarctions) compared with traditional NSAIDs.[2]

Note For All Steps:
- Physicians are advised to follow-up with periodic laboratory monitoring and assessments for standards of practice.
- *Italics* indicate agents that are currently covered under the Medi-Cal List of Contract Drugs; however, *covered items are subject to change*.

DISEASE is Advancing or PROGRESSING

Labs: RF & ESR or CRP[1]
Rule out hepatic disease prior to initiating therapy with MTX or Leflunomide.

X-Rays of hand and feet

Combination therapy is superior when compared to single DMARDs [4]
- *Leflunomide* + DMARDs ▪▪▪ MTX + *HCQ* + *SSZ*[4] ▪▪▪ *MTX* + *SSZ* + *prednisone taper* ▪▪▪ *MTX* + *SSZ* ▪▪▪ *MTX*+ *leflunomide* ▪▪▪ *MTX* + cyclosporine▪▪▪ *HCQ* + cyclosporine

If failure OR partial response, then

Injectable monotherapy OR combination DMARD with:
- Subcutaneous: TNFa Inhibitors (adalimumab or etanercept) OR interleukin-1 inhibitor
- Intravenous interleukin-1 Inhibitor

Note: Biological injectable agents should be prescribed and care monitored by a rheumatologist
- Incidence of infections has been less evident with the interleukin-1 inhibitors than with TNF.[5]
- Post marketing surveillance has demonstrated an increase in infections, especially opportunistic infections and a reactivation of TB. Baseline chest x-ray and PPD prior to the initiation of TNF[6]

Severe Progressing

Add Step Up combination therapy (failed TNFa +MTX)
- TNFa + *leflunomide or azathioprine*
- **Prosorba column**
- **Surgery**

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